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# Domestic violence and mental health in older adults

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## **Declarations of interest**

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

## Abstract

The link between mental health and domestic violence is clearly established in working age adults, but the literature on adults over the age of 65 is patchy. Assumptions are made about older adults within this field that need to be explored. We examined the literature in this area, and established that prevalence figures are variable but the likely lifetime prevalence for women over the age of 65 is between 20 and 30%. Rates of emotional abuse appear to be stable over the lifespan, but physical abuse decreases with age.

There is a strong association between being a victim of domestic violence and experiencing increased rates of mental and physical health problems in older adults. The scarce research comparing the impact of domestic violence across the age cohorts suggests that the physical health of older victims may be more severely affected than younger victims.

There is evidence that older victims may experience less psychological distress in response to domestic violence than younger victims. Identification of couples experiencing domestic violence is poor in the over 65's and there are very limited options for onwards referral after identification. Internationally the management of domestic violence in older adults is sparse and lacks cohesiveness.

## Introduction

The World Health Organisation (2010), defines intimate partner violence as '*behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours. This definition covers violence by both current and former spouses and partners.*' In this paper we use the term domestic violence, with a specific focus on intimate partner violence. . Our emphasis is on the older adult population, particularly the over 65s. As research into older adults uses varying age ranges, some of which include people from the age of 55, we have included some adults younger than 65 in order to match the body of research available to us.

In this paper we reviewed Medline, PsycINFO, Cinahl and Embase applying the following inclusion criteria: English-language papers, mental health and domestic violence in older adults, and used citation tracking from relevant articles identified to select further papers. We also drew on the results of a systematic review we were concurrently undertaking into the elder abuse and dementia literature.

## Domestic violence across the lifespan

Domestic violence affects every age group, and is present throughout the life span although it may manifest differently in older adults. Surveys suggest the lifetime prevalence for domestic violence in the over 60's may be anything from 5.36% (Zink et al., 2005) to 26.5% (Bonomi et al., 2007).

In a recent national survey in Germany, Stokl and Penhale, (2015) reported that current intimate partner prevalence for all types of intimate partner violence was 27% for women over the age of 65, 30% for women aged 50-65 and 33% for women aged 16-49. In 2013 the World Health Organization

published a report in which they state that the global lifetime prevalence of intimate partner violence among ever partnered women is 30.0%. They break down the prevalence data by age, and for women aged 65-69 they report that the global prevalence is 22.2%. They do not have any data for women over the age of 70. They comment however, that most of the data does not include information for women over the age of 49, and therefore this data should not be interpreted as meaning that older women experience lower levels of intimate partner violence, but rather that less is known about this age group (WHO 2013).

There is evidence of the health impact of domestic violence on working age adults, with high rates of physical and mental health problems in both female and male victims (Ferari et al., 2015, Hester et al., 2015, Howard et al., 2010,) and male perpetrators (Hester et al., 2015). However the impact of domestic violence on older adults has been less of a focus, and the research into this area is patchy and largely unsynthesized. The relevance of age may seem unclear, and in the UK, where the focus in some areas is on integration and ageless provisions, it could be argued that extrapolating the data for younger people would be sufficient.

However, those who work with older adults will be aware that there are important differences between the age groups, with older people presenting to services in different ways and facing different challenges. Issues such as health, self care at home, financial security, inheritance and loneliness are paramount for older people, and set this age group within a different context when it comes to intimate partner violence and their responses to it. Within the NHS, services continue to be provided separately to older adults, both in mental health and acute medical trusts, as a result of these differences.

### **Domestic violence and elder abuse**

Intimate partner domestic abuse in older adults sits awkwardly within and alongside the sphere of elder abuse, and research into elder abuse includes couples where violence has been longstanding, but does not always identify these couples and consider them as a discrete subset. Within the elder abuse literature there are frequent references to a link between pre existing relationship difficulties and severity of elder abuse, but this group of older people are not separated into a subgroup at any point for separate analysis (Buttell, 1999, Compton et al., 1996, Cooper, 2009, Coyne et al., 1993, Yan, 2014).

In his paper on the relationship between spouse abuse and the maltreatment of dementia sufferers by their caregivers Buttell, (1999) discusses the relatively separate areas of spousal abuse and elder abuse and the difficulties resulting from the development of separate bodies of knowledge in these areas. This paper was published over 16 years ago, but these issues remain pertinent and relevant today.

### **The nature of domestic violence in older adults**

In all age groups, domestic violence may involve more emotional and psychological abuse than physical violence (Office for National Statistics (ONS) - 2013/2014). It is thought that domestic

violence is even more emotional and less physical in older adults (Band- Witterstein and Eisikovits, 2009, Roberto et al., 2014). This theory is supported by a recent survey in Germany of 7257 women of all ages by Stockl and Penhale, (2015). They reported that in older women over the age of 65, 1% described past year physical or sexual violence. This compared to 8% of women aged 16-49, and 3% of women aged 50-65. These figures demonstrate a reduction in rates of physical violence over the years, and provide a useful comparison between older and younger women, which is lacking in other studies. In the same study, other types of abuse remained more stable across the lifespan, with 13% of women in all age groups reporting emotional abuse in their current relationship, and 21% of women in all age groups reporting controlling behaviour. There was a very slight increase in economic abuse from 12 % in women aged 16-49 to 13% in women over the age of 65. **This reduction in physical violence may, in part, reflect the physiological changes in the brain and its development over the lifespan. The frontal lobes and associated neuronal tracts provide the tone for reducing violent behaviour through impulse control, and they are not matured until well into a persons 20's (Lebel and Beaulieu, 2011). One would expect rates of physical violence would decrease as a result of this brain development.**

Some of the variation in prevalence of psychological abuse between studies may be due to the different definitions and questions asked, as well as the abuse being defined over different timescales. Some scales include one off episodes of being criticised, whereas others require a higher threshold of harmful behaviours. The rates of physical violence in Stokl and Penhales survey compare to the 8% found in the Crime Survey England and Wales 2013/2014 (ONS 2013/2014) for all adults.

### **The psychological and emotional impact of non-physical domestic violence in older adults**

Assumptions that the impact and severity of abuse will be increased with the presence of physical and sexual violence need to be questioned. Victims of all ages report that non-physical abuse is often more harmful than physical violence, with younger women reporting that emotional abuse has a higher negative impact on them than physical abuse (Marshall, 1996). In their qualitative research on older women who experience non-physical abuse in the USA, Seff et al., (2008) reported that women described the criminal justice system as being unable to respond to emotional abuse in the way that they can respond to physical abuse. They talked about the impact of abuse on their confidence and how quickly and comprehensively non-physical abuse could affect their lives, so that they ended up unable to make any decisions for themselves.

These women reported that non-physical abuse was as bad or worse than physical abuse because of the nature of it. One woman said that 'when it comes out of the mouth it comes straight from the heart....Words hurt more than a beating' (Seff et al., 2008 page 366) another is documented as saying 'they don't know sometimes mentally it's even more damaging. That's what's hidden, that's what never comes out' 'a punch, a wound, is going to heal.... But the psychological abuse terminates you....many women don't know it, but it is the worse crime' (Seff et al., 2008 page 367)

This view, that psychological, non-physical abuse could be more damaging than physical violence, is supported by the findings of Mouton et al., (1999). They surveyed 257 women between the ages 50 and 79. They asked questions to detect domestic violence and reported that 31.9% had experienced

domestic violence at some point in their life. Women who had been threatened had lower mental component summary (MCS) scores as well as lower 'Role-Emotional' scores (these are markers of mental health status) compared to women who hadn't. The association between poor mental health and women who had experienced only physical assault without threats was less marked, implying that it is the presence of threat or psychological harm, that has the greatest impact. In this survey women who had been threatened also reported generally poorer physical health and increased pain when compared to women who had not been threatened.

In a later survey by Mouton et al., (2010) 93,676 women aged 50-79 were investigated in the USA. They reported that 11.1% of respondents described some form of physical or verbal abuse. As part of their survey they asked people to complete the mental component summary (MCS) from the RAND 36 item health survey. They found that where verbal abuse was involved in the abuse pattern, there was a significant negative impact on the MCS scores, whether physical violence was involved or not.

These findings support the idea that non-physical abuse is, at least as, if not more harmful than physical abuse and has significant wide reaching psychological effects on those who experience it.

### **III health, dementia and domestic violence at the end of the lifespan**

Health and dementia are key issues within the considerations of older people and intimate partner violence. Older people suffer more from ill health, and this will impact their view of themselves, their needs within relationships and their responses to mistreatment from others. Dementia is more common as we age, and with an aging population it is projected that there will be 1 million people with dementia in the UK by 2021 (Alzheimers society 2013). The elder abuse literature has looked at the link between dementia and elder abuse, and findings indicate that patients with dementia are more at risk of elder abuse than those without (Dong et al., 2011, Dong et al., 2012, Sasaki et al., 2006 Vida et al., 2002). Dong et al. in their study of 143 dementia sufferers found that the risk of elder mistreatment increased with every small decrease in cognitive function. The lowest tertiles in global cognitive function were associated with an odds ratio of 2.71 for elder mistreatment (Dong et al., 2014).

Within the elder abuse literature, the intimate partner violence population is not often differentiated. In some studies it is possible to identify when abuse is occurring at the hands of an intimate partner or close family member, but this is not always the case, and by definition elder abuse can be perpetrated by anyone involved in the patient's care, including paid carers.

When trying to identify that group of patients who have experienced domestic violence prior to the development of dementia, there is often little or no reference to the previous relationship quality. When it is described, it is often couched in vague terms such as 'poor premorbid relationship' (Compton et al., 1996), which does not allow us to determine the definite presence of premorbid domestic violence.

In our recent systematic review of domestic abuse and dementia, we concluded that family member domestic violence may be more likely in patients with dementia than patients without dementia. We identified only 2 studies of elder abuse that recorded the relationship status of the perpetrators of

abuse, and also referred to a control group which could provide a comparative risk of domestic abuse. The pooled odds ratio for risk of domestic abuse with dementia was 2.68, implying that having dementia may increase the risk of domestic violence from a family member (McCausland et al., under review).

Part of this increase could be due to ill health and dementia causing an increase in frailty and dependence on others for support. People who are unwell are vulnerable and have less ability to defend themselves from physical attack and verbal assaults. They can be neglected and denied food and water if they are immobile. They can also have continence needs which can be used as a vehicle for abuse. Introducing new demands and needs into a relationship which is abusive, can change the system in unpredictable ways, and these things are issues for victims and perpetrators of abuse alike. People who have been victimised over long periods of time, may struggle to provide care for the perpetrators of the abuse.

Equally, it may not be surprising if perpetrators make poor carers, and as mentioned earlier, a poor premorbid relationship is a strong predictor for elder abuse (Buttall, 1999, Compton et al., 1996, Cooper, 2009, Coyne et al., 1993, Yan, 2014). In our exploratory study regarding 20 couples with a history of domestic violence (Knight and Hester, 2014) we found that providing care for each other after the onset of dementia was too challenging for more than half of couples. In this study, there were often safeguarding concerns raised about the quality of care provided both by the perpetrators of domestic violence, and by the victims.

### **The impact of domestic violence on the psychological wellbeing and mental health of older adults**

To think about the psychological impact of domestic violence across the life span we need to consider the psychological challenges and tasks facing older adults. In the late 20th century Erik Erikson proposed a series of psychosocial crises that are foremost at different times across different ages. For adults over the age of 65 he proposed that the psychological crisis was 'integrity versus despair'. His theory suggested that success in this life stage would lead to wisdom which results from being able to look back on one's life with a sense of closure and completeness, and then to accept death without fear. Erikson believed that if at this later point in life we see our lives as unproductive or feel that we did not accomplish our life goals, we can become despairing, leading to depression and hopelessness.

It is not hard to imagine, how older women who have experienced long term abuse, might find this psychosocial crisis hard to navigate. The bitterness and disappointment could be overwhelming, and this seems to be embodied in the statement quoted by a woman in the study by Band-Winterstein and Eisikovits, (2009), 'Fifty years isn't enough? I am a sick woman, and he doesn't give me any rest.....He can't do anything to me any more. I said that the social worker should take him to a nursing home. I hate him. I can't look at him. I won't forgive' (Band-Winterstein and Eisikovits, 2009 page 173).

Band-Winterstein and Eisikovits, (2009) looked at individual older women and men who had experienced domestic violence through most of their adult lives, and listened to their stories. With

this study, the themes emerged of finding things harder over time, and feeling less resilient to abuse as they aged. Older women spoke of the double burden of poor health and intimate partner violence and how they could not bear it any longer.

Older adults experience all the same psychological effects as younger adults as a result of domestic violence; the wearing down of their confidence, the restriction of opportunities for success and personal growth and at times severe social isolation. However, for older adults there are also added psychological burdens. They may have been subjected to domestic violence over many years, for some the whole of their adult life. They may also experience the loss of hope of change or apology. In the small exploratory study by Knight and Hester, (2014) looking at domestic abuse and dementia, one older woman who had experienced abuse throughout her married life recounted how she was very disappointed in herself for returning to the marriage after leaving. She said that 'she returned in order to hear him say how much he loved her and the children and to acknowledge to them all how much he had damaged them. She is still waiting for this to happen.' 'I was just waiting for him to come home and say sorry...and he never did' (Knight and Hester, 2014 page 12). For this woman the difficulties were compounded when she developed dementia and became dependent on her husband for everyday support.

Another theme that arose in this study was that of loneliness, and the fear of loneliness. One older woman reported that 'I guess my fear of being alone is so strong that it's...I'm willing to tolerate anything to avoid it' (Zink et al., 2003 page 1438). Loneliness is not confined to older people, but the perception is often that older people are less likely to find new relationships (Zink et al., 2003). Loneliness is the subject of a large body of research, and is linked to poorer mental health outcomes (Ong et al., 2015), and loneliness can be experienced within a violent relationship as a factor that increases tension and conflict (Ron and Lowenstein, 1999). In their qualitative study on older women living and coping with domestic violence, Lazenbatt et al., (2013), quoted a woman as saying 'My life is not happy or full of family and friends. I feel totally alone. My husband hated my family and friends and systematically removed them from my life. I am now angry that I allowed him to do this. A lonely life into old age leaves me with dread' (Lazenbatt et al., 2013 page 30).

A sense of being trapped and unable to leave may worsen the emotional and psychological harm that results from the abusive relationship. Older adults may feel less able to leave abusive relationships and are less likely to access voluntary sector support to help them cope with the difficulties and plan for their safety (Beaulaurier et al., 2007, McGarry et al., 2012). They may feel guilty about leaving a now frail, albeit abusive, partner who may rely on them for care and support with everyday living. Zink et al., (2003) published a qualitative study looking at reasons why older women remain in abuse relationships, one woman stated 'I can't let him go to the dogs' (Zink et al., 2003 page 1437). Older victims may also face financial restraints that can limit their sense that they can leave, as they may want to safeguard an inheritance, or have only a small pension (Tetterton and Farnsworth, 2011).

So older people experiencing domestic violence, struggle with many of the same psychological challenges as their younger counterparts, but also face other hurdles specific to their age such as poor health, loss of role with retirement, length of time exposed to domestic violence and the challenge of facing the end of their life.



The combination of the physical and psychological burdens of domestic violence that occur at any age with the increased physical vulnerability that occurs with increasing age, would seem likely to result in a high impact of domestic violence in older adults. One of the questions here is whether the increasing wisdom and psychological resilience that is reported to occur with increasing age might offset any of the damage done within violent relationships (Creamer and Parslow, 2008). When considering the mental health of older adults, disorders that are highly affected by emotional states and stress are also important. These would often be described as 'psychosomatic' or 'psychological' and would include disorders such as fibromyalgia, irritable bowel and chronic pain. When evaluating the impact of domestic violence on older adults these other disorders should also be taken into account.

The research into mental health sequelae of domestic violence focusses on many different types of disorder, varying from specific diagnosed depression (Fisher and Regan, 2006, Hester et al., 2015, WHO 2013, Wilke and Vinton, 2005, Zink et al., 2005), to vaguer measures of psychological distress (Mouton et al., 1999, Mouton et al., 2010, Stokl and Penhale, 2015). However, whichever way it is measured or categorised, research focussing on the mental health of older adults experiencing domestic violence shows an increase when compared to older adults in non-violent relationships. There are also significant effects on physical health measures across the board (Fisher and Regan, 2006, Hester et al., 2015, McGarry et al., 2011, Mouton et al., 1999, Mouton et al., 2010, Stokl and Penhale, 2015, Zink et al., 2005).

The most commonly measured mental health problems are depression and anxiety. Fisher and Regan, (2006) investigated this in 842 women over the age of 60 in Indiana, Ohio and Kentucky. They found significantly raised odds in women who were identified as abuse victims of suffering from depression and anxiety, as well as digestive problems and chronic pain. Overall women who identified as abuse victims also reported a significantly higher number of other health conditions compared to non-abused women. However, the greatest impact in this study was on depression and anxiety where the adjusted odds ratio was 2.24 in the abused women.

In their review of post menopausal women Mouton et al., (2010) also found that as well as a lower mental component summary (MCS) score, women who were abused had significantly increased depressive symptomatology, and worse scores on all mental health subsets, compared with non-abused older women.

A prevalence study in 2005 by Zink et al., surveyed older women about health and mental health. They showed a trend towards increased morbidity in women who identified themselves as victims, and there was significantly increased prevalence for depression and anxiety. Here 49.1% of women who identified as being victims reported depression or anxiety compared with 30.4% of women who did not identify as victims. Victims also reported higher prevalence of chronic pain, and strokes or nerve problems but these did not reach significance.

This theme was continued by McGarry et al., (2010), in a qualitative study researching how domestic abuse affects the well being of older women. She reported that women in her study had experienced a number of psychological problems at the time of the abuse, but also later in life. These included panic attacks and acute anxiety. A woman described her experiences: 'The long-term

impact on my health has been depression...I had it then when all that was going on and now for 10 years ...nearly 12 years' (McGarry et al., 2010 page 35). This study raises the long term nature of the impact of domestic violence. How earlier trauma might lead to long lasting vulnerability to psychological distress even after the abuse has come to an end.

In their qualitative study Lazenbatt et al., (2013), report that the women described severe depression, and anxiety, with treatment with tranquilisers, antidepressants and sedatives over many decades. Six women in this study were being treated for addiction to tranquilisers. One woman said 'My husband (a general practitioner) got his medical partner to prescribe Valium for me in the 1970's and I am still taking it. I know I am addicted to it'. This paper emphasized the problems with addiction that the women faced, including alcohol misuse 'My children see me as an "old drunk". I feel ashamed' (Lazenbatt et al., 2013 page 30).

The link between addiction and domestic violence is well established in working age adults (WHO 2013), but we found that there is much less information regarding this in older adults. Wilke and Vinton, (2005) showed that women over the age of 45 were more likely to drink alcohol daily than the younger women, however this did not include the over 65s. In their research on 38 women in abusive relationships between the age of 54 and 90, Zink et al., (2006) found that 39% reported substance abuse problems. However, in general, research on older adults has tended to focus on physical health problems alongside the mental health issues, and quantitative studies on addiction are scarce.

What does emerge from the research body is a link between length of exposure to domestic violence and long standing psychological vulnerabilities and difficulties. This link is explored in the study undertaken by Cisler et al., in 2012. In their study on mistreatment and self reported emotional symptoms they used survey data on 5777 adults aged 60 and over, to investigate the impact of elder abuse. In this study, they found that the impact of recent elder abuse, was greatly increased with regards to emotional and functional impairment, in respondents with a history of prior traumatic events. These participants were more vulnerable to current mistreatment, than those who did not report prior traumatic events. This suggests that trauma experienced in earlier adult life in some way predisposes people to responding to later trauma with higher levels of distress, and greater functional impairment than for those who do not have the earlier history of trauma.

The link between earlier exposure to trauma and long term effects is explored further in the recent review by Lohr et al., (2015) investigating the question; 'Is Post-Traumatic Stress Disorder Associated With Premature Senescence?' They included 32 studies in a quantitative synthesis, and found an association between post traumatic stress disorder (PTSD) exposure and an increased risk of multiple physical health problems, premature death and an increased risk of dementia. They considered whether PTSD accelerates the ageing process, and concluded that it did. That exposure to traumatic events has a whole body effect, with changes in both the physiology and psychology of those exposed to trauma. The link between PTSD in early life, and the later onset of dementia is a significant concern for women experiencing domestic violence, and would constitute another burden for older women who have been traumatised within violent relationships during their adult life. This review found that all three studies that examined PTSD as a risk factor for dementia reported positive findings.

The theory that exposure to trauma has effects on every body system, is borne out in the research into health and domestic violence in older women. Many of these women have been exposed to domestic violence over many years and decades, and all of the research shows an impact on both their mental health and their physical health with increased likelihood of cardiovascular and gastrointestinal disease among other variables.

The studies described above, compared the prevalence of mental health problems between abused and non-abused older women, but did not compare the impact of domestic violence on younger women compared with older women.

In their paper 'The Nature and Impact of domestic violence across age cohorts', Wilke and Vinton, (2005) undertook a secondary analysis of the US national violence against women survey which was undertaken in 1995 and 1996. This survey used telephone interviews of 16000 women across the USA. 398 women reported being victims of domestic violence within 5 years of the interview. These women were split into age groups 18-29, 30-44 and 45 and older. This showed significant differences between these age cohorts for many variables. A chronic mental health condition was reported by 14.8% of the older age cohort, compared to 3.2% by the younger age cohorts. Older women also reported higher rates of chronic disease, antidepressant use and other psychotropic drugs. However, on psychosocial functioning measures, there was either no difference, or the older women performed slightly better.

Stockl and Penhale, (2015) also compared age cohorts, and they included older women in a separate cohort. They interviewed 4448 women aged 16-49, 2030 women aged 50-65 and 779 women aged 66-86 who were identified in a national survey in Germany. The interview process began with face to face interviews and then involved a written questionnaire completed alone. They identified different types of intimate partner abuse, including physical or sexual intimate partner violence, emotional abuse, economic abuse and controlling behaviour. They then calculated odds ratios for different health symptoms for the 3 groups of women. These odds ratios were calculated against non abused women of the same age. For 'strong psychological problems' the odds ratio is 2.96 for women aged 16-49, 2.45 for women aged 50-65 and 2.53 for the older women. These figures are all significantly raised compared to non abused women, but are similar across the age cohorts. For psychosomatic symptoms the oldest age group showed the lowest odds ratio, and this was also true for 'mild psychological problems'. This supports the findings in the paper by Wilke and Vinton (2005), which showed a better reported level of everyday psychological functioning by older women exposed to domestic violence, whilst also finding that they are experiencing higher levels of mental health problems. It is hard to understand these findings, as more severe mental health problems are normally associated with poorer psychosocial functioning.

These findings form part of an emerging picture of the impact on older adults experiencing domestic violence. There seem to be strong links between poor physical health in various domains, as well as increased rates of depression and anxiety. These are coupled with the possibility that for older adults their psychosocial functioning is less impaired than might be assumed from the co-morbidities. This may be a function of increasing wisdom with age, as well as being related to the way that domestic violence is viewed within that age cohort, and the relative merits of remaining married and coping, versus the shame of divorce or separation.

There are significant questions being raised by emerging research regarding the long term impact of exposure to trauma, and the possibility that this may lead to premature mortality. This question is not investigated in any of the available research relating to domestic violence in older adults, which do not report on mortality rates.

### **The impact of perpetrating domestic violence in older adults**

The literature investigating the link between perpetrating domestic violence and mental health is scanty. In 2014, Oram et al., published a systematic review and meta analysis of psychiatric disorder and the perpetration of partner violence. They found that although data was scarce, a history of psychiatric disorder increased the odds of perpetrating domestic violence against a partner to between 2 and 3 for both men and women with psychiatric diagnoses. (Oram et al., 2014). Their review did not differentiate perpetrators or victims by age. Shorey et al., (2012) investigated the prevalence of mental health problems in younger men arrested for domestic abuse and court-referred to Rhode Island batterer intervention programmes. The average age of men in this sample was 33. They found depressive symptoms positively correlated with severity of psychological abuse perpetrated ie, the more severe the psychological abuse perpetrated, the more severe the depressive symptoms reported. This link was also true for anxiety disorders amongst the men.

Hester et al., (2015) investigated the link between perpetrating negative behaviours and health in men in General Practice. They found that perpetrating negative behaviours including perpetrating domestic violence, was associated with an increase in the odds of anxiety and depressive symptoms. The association was also present for men who reported being victims of negative behaviours and those who reported both perpetrating and being victims. This sample included men who were over the age of 65 but does not report on these older men as a subgroup. Despite the lack of research into older adults and perpetration of domestic violence, the evidence from younger adults points to a clear association between poor mental health and perpetration. This is likely to persist into later life, but the other issues that arise in later life may change some of the features of perpetration and its impact.

A striking finding in the qualitative study by Band-Winterstein and Eisikovits, (2009) involving older adults, is how men who perpetrate violence have psychological processes that minimise the violence, decontextualize their spouses' responses to their abuse and through strongly held opinions, achieve a view of themselves, the perpetrators, as victims. When describing the view of one of the men in the study, who had perpetrated abuse over his adult life, the author stated that 'he perceives himself as nonviolent, as a person who would never even hurt an animal, and as a victim of his wife's emotional abuse. She is described as a person who constantly attempts to cause him harm.' (Band-Winterstein and Eisikovits, 2009 page 172). This highlights the difficulty with perception of perpetration within violent relationships, which is also echoed in the literature on younger age groups, although the generational issues may also provide a particular context for perpetrators seeing themselves as victimised.

### **Identification and management of domestic violence in older adults**

Internationally there is little evidence that any countries are delivering a cohesive response to domestic abuse in later life. The 'Elder abuse and neglect in the European Union, UN Open-ended Working Group on Ageing, 2012', stated that, with regards to elder abuse 'there is no comprehensive EU-wide response on this issue, especially one of a binding nature' (Georgantzi, 2012). Equally in the USA there are a variety of agencies involved in responding to late life domestic abuse, but the provision and range of these varies around the country (Aravanis, 2006).

Because of the lack of information about international strategies for managing domestic violence in older adults, our focus in this section will be on UK services.

Over time considerable provision of largely non-governmental, voluntary sector, services for domestic abuse has developed in the UK, but targeted mainly towards working age adults and the protection of children. Compared to working age adults, older adults may have a different view of themselves and of marriage, and this affects their likelihood of raising issues of domestic violence and abuse with others, and of seeking help with these relationship issues and . The identification of older adults who are experiencing domestic abuse, and who are wanting help or support is challenging. McGarry et al., (2012) in their report on service responses to domestic abuse affecting older people, sought the views of older adults in violent relationships and despite extensive outreach, but only three older people came forward for the study. McGarry et al., (2012) identified that the focus of provision of services was generally on younger adults, mostly in the age range 25-45. They spoke to voluntary sector providers and quote one Independent Domestic Violence Advisor as saying 'if you are a 70 year old woman or man you're offered refuge, I don't think I'd go!' (McGarry et al., 2012 page 18).

A social worker in the same study is quoted as saying 'The refuges that we have ... the nearest ones that I know of are all for younger women and they often have children there and they're totally unsuitable for older women....we have used residential care, again its not the most ideal place ...its not the most pleasant environment for someone who's otherwise well but is having to cope with a separation from a husband who she's been with an awful long time' (McGarry et al., 2012 page 25).

They also highlight the overlap between elder abuse and domestic abuse in the older age group, and how this can be confusing to all parties. The previous domestic abuse can be relatively hidden within the current situation, where one party may be caring for the other due to recent physical health problems or dementia.

In our exploratory study (Knight and Hester, 2014), none of the couples were supported by the voluntary sector. One couple had been referred to the local domestic abuse services, but had been redirected to Age UK (a UK based charity for older adults) for support. Age UK had not responded to this request and the patient had given up trying to get help at this point. Identification of abuse in our study had occurred primarily as a result of physical abuse being reported, and there was no evidence of patients or carers being asked about domestic abuse directly as part of a normal assessment. Within the older adult psychiatry services across the UK, the issues of domestic abuse remain poorly recognised and routine screening questions relating to domestic violence are not normal practice. Patients are increasingly asked about domestic abuse in some general practices, but it is not clear if this includes over 65s (Feder et al., 2011)

Another theme that emerged in our research was the issue of older people not recognising themselves as victims of domestic abuse, instead they tended to minimise the difficulties and conflict within their relationships. Identifying and supporting people within abusive relationships is much more difficult when the people involved are not acknowledging the difficulties, and are not seeking help. Where they might want to seek help there are numerous barriers to this such as frailty, guilt about leaving partners who might be unwell themselves, financial issues and family worries (Beaulaurier et al., 2007).

This raises the question of how we should be supporting older adults who are in violent abusive relationships. We need to be mindful to respect their views and position, and their right to continue within lifelong relationships despite the apparently harmful effects of that relationship. We need to be cautious about determining the extent of that harm when viewing the relationship from the outside. And we need to reflect carefully on the harm of intervening, and how this would be viewed within the marriage or partnership concerned and by the family of those involved. As we have seen earlier in this paper, older adults report lower levels of psychological harm as a result of domestic violence than younger adults (Stokl and Penhale, 2015, Wilke and Vinton, 2005).

Introducing standard questions on domestic abuse at assessment within mental health services could pose some added difficulties compared to with younger adults. As an old age psychiatrist, my experience is that older adults tend to attend mental health clinics with their partners and may be reluctant to disclose abuse in the presence of their spouse or partner (Tetterton and Farnsworth 2011). In their guidance on domestic violence, NICE suggests that staff do not talk to partners together about relational issues (NICE 2014).

Then there is the issue of what to do with the information gathered. There are no clear referral pathways for domestic violence in older adults, and as we have seen before, the voluntary sector in the UK do not routinely offer age appropriate interventions and support. Older women are much less likely to access interventions such as refuges, and perpetrator programmes are largely aimed at younger adults. There is also the problem that the effectiveness of these types of interventions remains uncertain, and research is ongoing (Ellsberg et al., 2015). Once the abuse is disclosed, what actions should be taken by the health or social care worker is unclear.

Social care services and more specifically adult safeguarding services (a service within UK social care services that safeguards vulnerable adults) tend to be the avenue for managing any significant identified risks relating to domestic abuse within older adult relationships in the UK. McGarry et al., (2012) recommend that safeguarding and domestic abuse services develop co-operative and collaborative multi-agency working, and that the voluntary sector ensure that they have the knowledge and skills necessary for working with older people.

In their article 'Intimate partner violence in late life: a review of the empirical literature' Roberto et al., (2014) discussed the theoretical frameworks, conceptual themes and methodological processes that cut across research in this area. They also highlighted the difficulties with a lack of theoretical understanding behind interventions and management strategies, and suggest that the way forwards for this group of individuals, is to be managed within multidisciplinary teams.

## Conclusions

Between 20 and 30% of older adults, the majority of whom are women, experience or have experienced domestic violence throughout their lifetime. In the over 65's there is less physical violence, but the rates of non-physical abuse seem to be stable across the lifespan (Stokl and Penhale, 2015).

The effects of the ongoing non-physical abuse are significant, and range from higher rates of mental health problems, to increased reports of poor physical health. There is emerging evidence that exposure to trauma at any age has an effect on every body system, and may lead to premature aging and early death as well as dementia (Lohr et al., 2015). This could have significant consequences for this population of women, as well as other groups of people experiencing trauma such as the armed forces. Premature death is something that has not previously been considered within the research literature, and could potentially represent a very significant outcome of domestic violence.

The association between perpetration and mental health issues is also apparent, but this literature is very scarce in older adults. The body of research into managing domestic violence, tends to focus on interventions that are developed without the strength and depth of understanding needed behind those interventions to make them effective and useful for older adults (Ellberg, 2015).

There are multiple areas for future research into older adults and abuse. These include how health professionals recognise domestic violence in older adults, investigating robust referral pathways for individuals and couples once they have been identified and the further investigation of the possible links between trauma and dementia. Current research into older adults rarely differentiates between intimate partner abuse, familial domestic abuse, and wider network abuse (elder abuse). Also lacking in older adult domestic violence, is research into personal factors that mitigate the effects of abuse, ie who copes better with domestic violence and why?

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